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Contents

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EDITOR'S NOTE

We Shall Not Cease From Exploration

Oliver M. Glass, M.D.

> We shall not cease from exploration
> And the end of all our exploring
> Will be to arrive where we started
> And know the place for the first time.
>
> —T. S. Eliot, *Little Gidding*

As I look back over the past 3 years, it is evident that the *Residents' Journal* has evolved in numerous ways. It has expanded its reach to all psychiatry residency programs in the United States and Canada, and it has assisted trainees with achieving a noble goal of publishing for the first time. As I reflect on this past year as Editor-in-Chief, I have come to realize that this journal is a source of compassion, humility, and perseverance. Time and time again, I have witnessed each editor dedicate his or her free time to improving the journal through individual mentorship.

Our social media presence has grown substantially, and our journal has been recognized as a source of literature that has an impact on medicine on a daily basis. Podcasts have been released consistently each month, allowing our followers to learn not only by reading but also by listening. Without a doubt, our journal's presence has grown exponentially.

I would like to thank the following editors who have assisted the journal's growth this past year: Shapir Rosenberg, M.D., Lindsay Lebin, M.D., Anna Kim, M.D., Matthew Edwards, M.D., Somya Abubucker, M.D., Erik Bayona, M.D., Alexander Cole, M.D., Jason Garner, M.D., David Latov, M.D., Carol Chan, M.D., and Elon Richman, M.D.

I welcome palliative care fellow, Shapir Rosenberg, M.D., as the new Editor-in-Chief. He will surely foster an environment of teaching and individualized mentorship. He was an outstanding Senior Deputy Editor, and I know that he will be an even better chief. I welcome the members of the future editorial board and recognize the quality of their talent.

At this time, my journey transitions into another phase. After completing 12 years of training since the beginning of medical school, I believe that I have grown and become enlightened in many ways. The person who I was prior to entering medical school is not the same person who is departing from forensic psychiatry fellowship training. The legendary Ten Ox Herding Pictures teaches the importance of returning to the ordinary marketplace after one becomes enlightened. This teaching should be applied to the field of psychiatry, because there is a desperate need for psychiatrists in underserved communities. I encourage all of you to contemplate on how you can enter the so-called marketplace upon graduation.

It is important to me to acknowledge my one and only love—my wife, Magdalena. She had been supportive throughout my psychiatry training and during my years as editor, sharing in the sacrifice as I spent countless hours helping this journal grow.

I end my tenure with the 44th verse from the Tao Te Ching:

> Which means more to you,
> you or your renown?
> Which brings more to you,
> you or what you own?
> I say what you gain
> is more trouble [than] what you lose.
>
> Love is the fruit of sacrifice.
> Wealth is the fruit of generosity.
>
> A contented man is never disappointed.
> He who knows when to stop is preserved from peril,
> only thus can you endure long.

Dr. Glass is a sixth-year forensic psychiatry fellow in the Department of Psychiatry, Emory University School of Medicine, Atlanta. Dr. Glass is also Editor-in-Chief of the *American Journal of Psychiatry Residents' Journal* (2018–2019).

ARTICLE

Evidence-Based Pharmacological Management and Treatment of Behavioral and Psychological Symptoms of Dementia

Juan Joseph Young, M.D.

Behavioral and psychological symptoms of dementia (BPSD), also known as neuropsychiatric symptoms, are a heterogeneous set of symptoms and disruptive behaviors that negatively affect patient care and significantly increase the burden on caregivers and family members (1, 2). BPSD has also been used as a broad, nonspecific term encompassing symptoms and behaviors that result from complex etiopathologies related to changes found in Alzheimer's disease, vascular dementia, and other neurodegenerative disorders (1). Consequently, BPSD may present in a variety of ways, including mood symptoms, anxiety, psychotic symptoms (e.g., hallucinations and delusions), impaired sleep, aggression, and agitation (3). Unsurprisingly, BPSD has been associated with higher rates of early institutionalization and costs as a result of these problematic behaviors and psychological symptoms (4, 5).

Although nonpharmacological options, such as exercise, cognitive therapy, and caregiver education, are the preferred initial treatment modalities for BPSD among elderly adults (6), clinicians may find themselves requiring more intensive management if symptoms fail to abate. In addition, there is an impetus for providers to employ alternative treatments to manage BPSD early to improve patient care and quality of life in the long-term. Thus, the aim of the present study is to educate providers about evidence-based pharmacological treatments for BPSD to improve patient care in the geriatric population. Note that this article is not intended to be a thorough systematic review of pharmacological treatments for BPSD but rather a narrative review, with a focus on educating providers about contemporary treatment options for these increasingly prevalent neuropsychiatric symptoms.

PHARMACOLOGICAL MANAGEMENT OF BPSD

Behavioral and psychological symptoms that could affect patient safety, patient health, and patient care may not be fully treated with nonpharmacological interventions alone. Therefore, pharmacological management may become necessary to stem and alleviate symptom progression. Several meta-analyses of studies investigating pharmacological treatments for BPSD have been conducted to aid physicians in employing evidence-based medicine when treating patients with dementia. The following sections detail current evidence regarding the use of several psychopharmacological classes in treating BPSD.

Antidepressants

A meta-analysis of several studies investigating antidepressants and their effect on agitation and psychosis symptoms that present in dementia indicated a reduction of agitation symptoms when patients were prescribed sertraline and citalopram, compared with placebo (7). In addition, these reports noted that there were no significant differences in outcome measures of agitation and psychosis symptoms between selective serotonin reuptake inhibitors (SSRIs) and first- or second-generation antipsychotics, although they also noted that citalopram had a better side-effect profile, compared with perphenazine. Nevertheless, the authors reported that SSRIs and trazodone were relatively well tolerated compared with placebo. This finding was supported by Henry and colleagues (8), who reported that eight trials demonstrated the benefits of using SSRIs and trazodone in managing BPSD, which was well tolerated by patients. More specifically, they found that most studies found benefits with sertraline, trazodone, and citalopram for BPSD, mixed results with paroxetine, and failed trials with fluoxetine and fluvoxamine. However, data are still limited on the efficacy of antidepressants for the range of symptoms in BPSD other than depression, which suggests that further research is needed to determine the primary role of antidepressants in BPSD treatment (9).

Antipsychotics

A meta-analysis by Ballard and Waite (10) investigating the use of second-generation antipsychotics for aggression and psychosis in Alzheimer's disease indicated a significant improvement in aggressive symptoms when patients were prescribed risperidone and olanzapine, compared with placebo. In addition, the authors found that risperidone caused a significant decrease in psychosis symptoms, compared with placebo. Another meta-analysis by Schneider and colleagues (11) provided evidence for the efficacy of aripiprazole and risperidone in the management of BPSD. However, the same group also conducted a randomized, double-blind, placebo-controlled trial and found that adverse effects of olanzapine, quetiapine, and risperidone may offset the advantages in efficacy of these antipsychotics in treating psycho-

sis, aggression, or agitation among patients with Alzheimer's disease, because the time to discontinuation of treatment favored placebo (12). This is important to note because the Food and Drug Administration, the Canadian Health Regulatory Agency, and the European Agency for the Evaluation of Medicinal Products have issued warnings about the association between increased cerebrovascular adverse events and antipsychotics such as risperidone and olanzapine (13). Accordingly, providers should always analyze risks versus benefits when prescribing antipsychotics to elderly patients, especially because adverse effects of antipsychotics could have a negative impact on a patient's health.

Mood Stabilizers

Konovalov et al. (14) indicated that out of the seven randomized controlled trials they reviewed, only one, which used carbamazepine, demonstrated a statistically significant benefit for BPSD presentations, compared with placebo. In addition, a review of valproate for agitation in dementia reported that low-dose sodium valproate was ineffective and that high-dose divalproex sodium was associated with too many intolerable adverse effects to be effective in the target population (15). In most of the studies reviewed, adverse effects were more frequent in the drug groups, compared with placebo groups, suggesting that mood stabilizers are relatively not well tolerated by patients with BPSD.

Alzheimer's Disease Treatments

Two meta-analyses indicated some efficacy regarding the use of Alzheimer's disease medications for the improvement of BPSD. One by Trinh et al. (16) reported that cholinesterase inhibitors produced modest improvements in neuropsychiatric and functional outcomes, compared with placebo. Another meta-analysis by Maidment et al. (17) reported that use of memantine to treat BPSD yielded modest decreases in scores on the Neuropsychiatric Inventory Questionnaire and improvement of symptoms, although sedation was reported to be a major side effect.

DISCUSSION

Initially, a trial of cholinesterase inhibitors or memantine may be used to delay the progression of cognitive decline and prevent worsening cognitive dysfunction, which may exacerbate BPSD presentations. Any cholinesterase inhibitors may be used because they all have similar efficacy and tolerability profiles (16). Next, treatment of BPSD may be based on the most significant symptom clusters affecting the patient (18). For example, use of antidepressants or mood stabilizers may be more beneficial for treating mood symptoms found in BPSD, whereas psychotic and delusional symptoms may benefit more from antipsychotics. Physicians should keep in mind the tolerability and adverse effects of these medications, especially regarding the black box warnings applied to antipsychotic use by geriatric patients.

Intractable BPSD presentations may be further managed with combinations of psychotropic pharmacological classes, depending on the symptoms that persist (19). Medications that do not provide acceptable benefits or are intolerable to patients should be tapered and discontinued before another trial is started. Caution should be used for combinations of psychotropics within the same medication classes because they may increase the risk of adverse events and side effects that could lead to significantly increased morbidity and possible death.

Even when medication trials are effective in improving BPSD presentations, the risks of continuing medications (especially in the geriatric population in which polypharmacy is rampant) should be regularly evaluated. Pharmacotherapy trials should be conducted until there is 3 or 4 months of clinical stability, after which medication tapers and eventual discontinuation should be initiated (20). Sensible and prudent use of antipsychotics should be reserved for BPSD presentations that are not sufficiently managed by other treatments. Antipsychotics should be prescribed only at the lowest effective dose and should be used for the shortest possible period, with close monitoring of any adverse events.

CONCLUSIONS

BPSD symptoms are a highly prevalent set of neuropsychiatric symptoms seen among patients with neurocognitive disorders as the disease process worsens, leading to a significant burden on patients and caretakers and poorer outcomes. BPSD presentations that do not improve with only nonpharmacological approaches may require augmentation with pharmacological therapy. However, providers should always note the risks of prescribing medications for these symptoms and behaviors, because drug therapy can cause severe adverse effects that should be carefully weighed against potential benefits. Therefore, medications should be prescribed only at minimum effective doses to decrease the risk of intolerable side effects, with a plan to taper and discontinue the medications when symptoms stabilize.

Dr. Young is a fourth-year resident in the Department of Psychiatry, MetroHealth Medical Center, Case Western Reserve University School of Medicine, Cleveland.

The author thanks Rajesh R. Tampi, M.D., M.S., F.A.P.A., for his contributions to this study, as well as for his guidance and mentorship.

KEY POINTS/CLINICAL PEARLS

- Behavioral and psychological symptoms of dementia (BPSD) are highly prevalent neuropsychiatric symptoms that result in poorer outcomes.
- Providers should focus pharmacological therapy on the most problematic symptom clusters and use augmentation for intractable BPSD presentations only when other treatment options have been exhausted.
- Antipsychotic prescribing should be routinely evaluated because of the black box warning for the geriatric population.

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COMMENTARY

Safeguarding Trainee Health: A Call for an Annual Opt-Out Mental Health Screening

Periel Shapiro, M.D., and Seth Barishansky, B.A.

There is an alarmingly high prevalence of depression among medical trainees. A 2016 meta-analysis of data from 122,356 medical students found that nearly a third were depressed (1). Another meta-analysis of data from 17,560 residents, published in 2015, found a similarly high rate of depression, with a prevalence estimate of 28.8% (2).

In 2017, the Accreditation Council for Graduate Medical Education (ACGME) instituted a requirement that training programs provide a "confidential, affordable mental health assessment" (3). In fulfilling the ACGME mandate, many institutions offer access to university counseling centers or community providers for a mental health evaluation.

Institutions that rely on self-referral to establish access to care are likely to miss many individuals in need. In one survey of house staff at Northwestern University, 110 residents and fellows felt that they would benefit from mental health care (4). Yet fewer than half of those trainees sought an evaluation. In another survey of 183 medical students at Yale University, 24.5% reported increased mental health needs during medical school, but fewer than half of those students increased their help-seeking behaviors (5). Many trainees may not self-refer because of stigma, manifesting as a fear of appearing weak or of facing professional consequences if discovered seeking care. Time and cost are also cited as barriers; programs may require that trainees seek an evaluation during their free time and pay out of pocket for services (4, 5).

Annual evaluation for every trainee would frame mental health care as a routine matter of health maintenance for all future physicians.

An annual opt-out mental health screening, included among other annual health care interventions, may mitigate issues associated with a self-referral system. By providing access to a no-cost evaluation in the same location and contiguous with workday time slots appointed for general health care needs, such as the influenza vaccine and tuberculin test, trainees will not have to sacrifice their limited personal time and funds in order to obtain an evaluation. An annual evaluation for every trainee would frame mental health care as a routine matter of health maintenance for all future physicians. A positive screen in the mainstreaming context of routine health maintenance may spur trainees to accept help before a crisis occurs.

Mental health is a prerequisite for optimal medical training. An annual mental health assessment for trainees, embedded among well-established trainee health care requirements, would serve both to minimize the barriers associated with a self-referral system and to reduce the stigma associated with mental health care.

Dr. Shapiro is a first-year psychiatry resident, and Mr. Barishansky is a fourth-year medical student, at Robert Wood Johnson Medical School, Rutgers University, New Brunswick, N.J.

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When Patients Cry

Jonathan Miller, M.D.

When patients cry
I encourage them to cry

The eyes swell shut
Saturated with sadness
Then comes the first drop
The solitary tear
The first messenger of inner misery
That is hastily wiped away
In a pathetic attempt
To delay others that might follow

For this onslaught could last a day
Or for forty days and nights
And there is doubt the vessel will hold
To weather such a storm
But instead be an ensnaring cage
Broken and dashed upon the rocks
Descending to the murky depths
As one is left to drown in their sorrows

But when patients cry
I encourage them to cry

Two by two we perfect the craft
Two by two we collect the best attributes
The rest are left out to the elements
In this man-made sanctuary
In this arc of solace
Patient and physician
We huddle together
Anticipating the tears
And the passing of final judgement

When the deluge finally arrives
The psyche is flooded with emotions
And feelings rage
Old sins are washed aside
Thoughts of wrath and un-forgiveness
Imperfections and accusations
All flow away with the edging tide
And when the wailing stops
When the floodgates close
Like exterior doors, the eyes are opened
Ready to explore this brave new world

When patients cry
I encourage them to cry

For the alternative is much worse
When no tears come
The soul becomes a parched desert
And the spirit wanders lost
In a place uninhabitable for life
Tormented by inner demons
Under temptation that can last a day
Or for forty days and nights
Until one simply gives in
To dwell among the bleached skeletons
Ghastly reminders of the flaws of one's past

So, when patients cry
I encourage them to cry

Dr. Miller is a resident in the Department of Psychiatry, Wright State University, Kettering, Ohio.

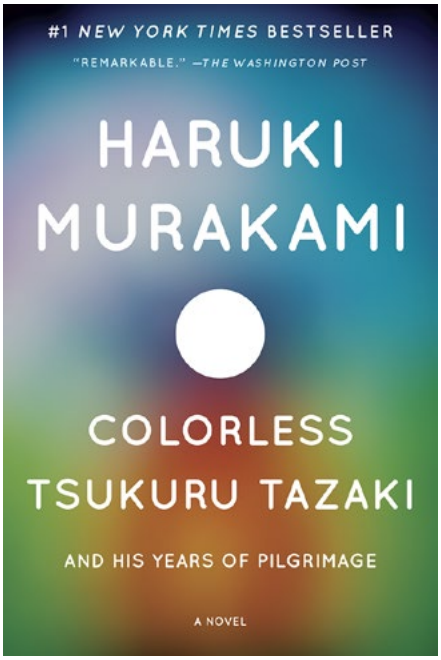
Colorless Tsukuru Tazaki and His Years of Pilgrimage: Through a Psychodynamic Lens

Reviewed by Joo-Young Lee, M.D., M.S.

Colorless Tsukuru Tazaki and His Years of Pilgrimage is a third-person narrative novel by the internationally best-selling author Haruki Murakami. The novel, which vividly illustrates the emotions, dreams, and fantasies of its characters in the face of traumatic events, lends itself to be viewed through a psychodynamic lens. This approach may help readers become sensitively attuned to the intrapsychic world of the protagonist, Tsukuru, and, more generally, to that of patients dealing with trauma.

Growing up with an invalidating father and with four high school friends who have colorful personalities, Tsukuru views himself as "colorless" and boring. His sense of colorlessness is heightened by the fact that each of his friends has a literal color in his or her name that defines their nicknames: Red, Blue, White, and Black. As a college sophomore, Tsukuru is abruptly abandoned by his friends with no explanation. For months following this event, Tsukuru experiences a severe depressive episode with suicidal ideation. As a defense, Tsukuru rationalizes the loss and isolates his emotions. During his adulthood Tsukuru loses other significant people, and the fear grows in him that someone he genuinely loves might suddenly disappear.

After more than a decade of life devoid of intimacy, the 36-year-old civil engineer finally finds his potential "self-object" Sara (who fulfills mirroring and idealizing needs, as described by Heinz Kohut), an assertive and empathic 38-year-old travel agent. Sara encourages Tsukuru to embark on a journey to elucidate the cause of his severed relationships, hoping this "pilgrimage" will resolve his fear of intimacy. As Tsukuru reconnects with the friends he once believed to be kaleidoscopic, he confronts the truth, which grants him a more cohesive narrative of his life and a "colorful" sense of self.



by Haruki Murakami. New York, Knopf Doubleday Publishing, 2015, 336, $16.00 (paperback).

The novel depicts numerous traumatic events and shows how different characters internalize traumatic experiences in unique forms of intrapsychic conflicts, defenses, fantasies, and dreams. The book addresses the notion that the quality of posttraumatic symptoms correlates more with personal psychodynamics (e.g., character traits or defense styles) than with the severity of the traumatic event itself. The novel displays not only how a traumatic event affects an individual victim but also how it has an impact on multiple individuals, especially regarding how victims' intrapsychic worlds may resonate and clash (e.g., victims' maladaptive defense styles may spawn secondary interpersonal trauma).

Sara's interventional approach to Tsukuru's tumultuous intrapsychic world resembles how a psychotherapist might help a trauma victim. She uses a trial interpretation (Tsukuru's avoidant behaviors might have resulted from his losing four friends) to evaluate Tsukuru's psychological mindedness and prioritizes dealing with his "resistance." Their unorthodox therapeutic (and primarily romantic) relationship seems to facilitate Tsukuru's bringing to light unconscious materials. However, because of the genuine yet embarrassing quality of these unveiled feelings and thoughts, Tsukuru fears that Sara might inflict additional trauma by abandoning him.

Can Sara remain Tsukuru's lover and therapist? Is Tsukuru a victim of unconscious repetition compulsion? Will he overcome his fear of self-assertion? Readers will enjoy the degree of freedom this book allows for formulating their own answers to these questions.

Dr. Lee is a first-year resident at the University of Maryland/Sheppard Pratt Psychiatry Residency Program in Baltimore.

LETTER TO THE EDITOR

Benefits of an Outpatient Neuropsychiatry Rotation

Aaron Winkler, M.D.

To the Editor: In the April 2019 issue, Drs. Lane and Lyndon (1) argued that postgraduate medical training should include "more neuroscience within psychiatric curricula and vice versa." They proposed "a two-pronged solution: integrating didactic curricula and building longitudinal clinical experiences." One clinical experience that fulfills this aim and might be integrated beneficially into both psychiatry and neurology programs is a year-long, full-day, outpatient neuropsychiatry rotation.

In PGY-1, residents in our psychiatry program rotate 1 half-day each week for 2 months in the neuropsychiatry program at Sheppard Pratt Hospital System under the supervision of the program director, Vassilis Koliatsos, M.D. The residents mainly see patients who have survived severe traumatic brain injury (TBI) or anoxic brain injury, although many patients with dementia, autism, and other developmental conditions are seen in the clinic as well. Stable patients are generally seen every 3 to 6 months, such that residents are unlikely to encounter the same patient twice during their 2-month rotation. As a PGY-3, I have had the unique good fortune to spend a full day in the clinic each week for an entire year. The value of the longitudinal experience cannot be overstated. In addition to seeing the natural course of illness unfold, there grows a meaningful doctor-patient relationship with patients—a relationship that residents rarely share with survivors of severe brain trauma or other neuropsychiatric conditions.

Importantly, the neuropsychiatry clinic is neither a neurology clinic nor a psychiatry clinic. It is both. Someone with a TBI from a car accident that occurred after years of alcohol use may have liver and kidney dysfunction from the accident or from premorbid substance use. This dysfunction might contraindicate lithium or valproate management of mood swings caused by, or worsened by, contusion to the right hemisphere. The same patient may also become violently aggressive with care staff and peers when levetiracetam is prescribed for posttraumatic epilepsy. But because of dense polypharmacy, the patient may be a poor candidate for carbamazepine therapy. Managing such complexity requires broad comfort with the pharmacopoeia and an awareness of nonpharmacologic treatments. Over the course of the full-year rotation, I have been pleasantly surprised to watch such patients make dramatic progress when there is careful, attentive management.

I agree with Drs. Lane and Lyndon. One possible implementation of their recommendation is a full-year rotation treating patients in a neuropsychiatric outpatient clinic. One hones neurological exam skills and knowledge of the neurological basis of disordered function, and one has the first-hand opportunity to build and deploy solid and varied pharmacologic knowledge. The very same clinic may allow neurology residents to expand their experience treating mood, obsessional, and psychotic disorders among patients with concurrent neurological dysfunction. Perhaps most important, neurology and psychiatry residents could profitably work side by side, building skill as clinicians and also rapport as colleagues.

Dr. Winkler is a third-year resident at the University of Maryland/Sheppard Pratt Psychiatry Residency Program in Baltimore.

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Residents' Resources

Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

To contribute to the Residents' Resources feature, contact Matthew L. Edwards, M.D., Deputy Editor (ajpresresource@gmail.com).

Fellowship/Award	**Academy of Consultation-Liaison Psychiatry (ACLP) Trainee Travel Award**
Organization	ACLP
Deadline	**July 1, 2019**
Brief Description	To encourage psychosomatic fellows, residents, and medical students to join ACLP and attend the annual meeting. A limited number of monetary awards are given to offset the cost of attending the annual meeting. (ACLP Council determines the dollar amount and number of awards.)
Eligibility	PGY-3 psychiatry resident or psychosomatic fellow.
Contact and Website	Web: https://www.clpsychiatry.org/about-aclp/awards/trai-trav
Fellowship/Award	**Transgender Psychiatry Fellowship**
Organization	Mount Sinai's Institute for Advanced Medicine
Deadline	**July 1, 2019**
Brief Description	This is a paid ($76,148 + conference/travel expenses) 1-year opportunity to work at the Center for Transgender Medicine and Surgery (CTMS) under the supervision of leading experts in transgender psychiatry. CTMS is located in the heart of New York City (Chelsea) and is a fully integrated clinic with medical, psychiatric, and surgical services provided. Available services include pastoral care, social work, and legal aid, all of which are tailored to transgender and gender nonconforming individuals.
Eligibility	Candidates must have completed a general psychiatry residency, have or be able to obtain a New York State license, and be board-eligible. Competency in LGBT-related mental health is desirable.
Contact and Website	Web: http://icahn.mssm.edu/education/residencies-fellowships/list/transgender-psychiatry-fellowship
Fellowship/Award	**Academy of Consultation-Liaison Psychiatry (ACLP) William Webb Fellowship Program**
Organization	ACLP
Deadline	**July 1, 2019**
Brief Description	This fellowship is designed to support residents and fellows in consultation-liaison psychiatry at an early stage in their careers and involves 1-year appointments in which each fellow will have a designated mentor and present a paper at the annual meeting. Financial support will be provided for each fellow's organizational membership for 1 year and for annual meeting registration fees.
Eligibility	PGY-3 psychiatry resident or consultation-liaison psychiatry fellow.
Contact and Website	Web: https://www.clpsychiatry.org/about-aclp/awards/webb-fship
Fellowship/Award	**American Academy of Child and Adolescent Psychiatry (AACAP) Educational Outreach Program for General Psychiatry Residents**
Organization	AACAP
Deadline	**July 12, 2019**
Brief Description	Provides the opportunity for general psychiatry residents to receive a formal overview of the field of child and adolescent psychiatry, establish child and adolescent psychiatrists as mentors, and experience the AACAP Annual Meeting in Chicago, October 14–19, 2019.
Eligibility	General psychiatry residents who are AACAP members or have pending AACAP membership.
Contact and Website	Web: https://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_General_Psychiatry_Residents.aspx

Information for Authors

Editor-in-Chief

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Senior Deputy Editor

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Upcoming Themes

Military Psychiatry
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If you are interested in serving as a **Guest Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Anna Kim, M.D. (annamegkim@gmail.com).

Submissions

The Residents' Journal considers manuscripts authored by medical students, resident physicians, and fellows in the United States and Canada; attending physicians and other members of faculty cannot be included as authors.

To submit a manuscript, please visit **https://mc.manuscriptcentral.com/appi-ajp**, and select a manuscript type for AJP *Residents' Journal*. See **https://ajp.psychiatryonline.org/residents_journal/rj_ifora** for more detailed instructions.

Article: Reports of novel observations and research. May include meta-analyses.

Drug Review: A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug interactions.

Perspectives in Global Mental Health: Should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow.

Case Report: A presentation and discussion of an unusual clinical event. All patient information must be adequately disguised, with written consent of the patient described.

Commentary: Generally includes descriptions of recent events, opinion pieces, or narratives.

History of Psychiatry: Provides a historical perspective on a topic relevant to psychiatry.

Arts and Culture: Includes introspective pieces, poetry, and reviews of books and films. All submissions must be relevant to the field of psychiatry.

Letters to the Editor: Comments on articles published in the *Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.

Manuscript Type	Word Limit	Maximum Figures and Tables	Key Points*	Maximum References
Article**	1,250	2	Yes	10
Drug Review	1,500	1	Yes	20
Perspectives in Global Mental Health	1,500	0		20
Case Report	1,500	1	Yes	15
Commentary	500	0		5
History of Psychiatry	500	0		5
Arts and Culture	500	0		0
Letters to the Editor	250	0		3

No abstract required for any article type.
*Box with 3–4 key teaching points
**Meta-analyses may be up to 1,500 words with 1 table or figure and 20 references.